Eat Well and Beyond, LLP
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Patient Registration Form (please print)

Name:			[ ] Male [ ] Female
Date of Birth: / /	Age:	Marital Status (circle) S M D Sep W	
Home Address:			
City:		State:	Zip:
Telephone Number(s):	Home ( )	Wk. ( )	Cell ( )
Occupation:			
Employed by:			
Business Address:			
City:		State:	Zip:

If child, person responsible for bill:			
Name:			
Relationship to patient: [ ] parent [ ] guardian [ ] other (describe)			
Home address if different from above:			
City:		State:	Zip:
Date of Birth: / /		Marital Status (circle) S M D Sep W	
Telephone Number(s):	Home ( )	Wk. ( )	Cell ( )
Referred by (health care provider):			
Address:			

Please provide insurance card(s)

Primary Insurance Company:	
Name of Policy Holder:	Date of Birth: / /
Relationship to patient: [ ] parent [ ] guardian [ ] other (describe)	

Secondary Insurance Company:	
Name of Policy Holder:	Date of Birth: / /
Relationship to patient: [ ] parent [ ] guardian [ ] other (describe)	

Patient or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or insurance benefits to myself or to Eat Well and Beyond, LLP. I request payment of benefits for Medical Nutrition Therapy (MNT) to Eat Well and Beyond, LLP.

Insurance Reimbursement: I understand that billing my insurance does not guarantee payment and that I am responsible for my bill, including any co-payment, co-insurance, deductible or balance due to insurance company denials.

Medicare reimbursement: I understand that I am responsible for my co-pay and any unmet deductible for MNT. I also understand that I am responsible for all charges for any diagnosis not covered by Medicare, and fees for visits denied by Medicare because they exceed the allowable number of visit hours. *Appointment cancellations must have a 24 hour notice.*

Subject to $25 Cancellation Fee if Less than 24 Hours Notice.

Signature:	Date: / /20__
E-mail address:	

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